MEDICAL CONTESTED CASE HEARING NO. 14063

DECISION AND ORDER

This case is decided pursuant to Chapter 410 of the Texas Workers' Compensation Act and Rules of the Division of Workers' Compensation adopted thereunder.

ISSUES

A contested case hearing was held on April 22, 2014 to decide the following disputed issue:

1. Is the preponderance of the evidence contrary to the decision of the Independent Review Organization that the claimant is not entitled to a sacroiliac joint injection with fluoroscopic control for the compensable injury of (Date of Injury)?

PARTIES PRESENT

Claimant appeared and was assisted by BP, ombudsman. Petitioner/Provider Dr. KB appeared telephonically as a witness in this matter. Carrier appeared and was represented by JL, attorney.

BACKGROUND INFORMATION

Claimant sustained a lumbar spine injury in the course and scope of his employment on (Date of Injury) when he slipped and fell, landing on his back, while trying to pull a cart containing thirty-pound hams into a refrigerator room. Claimant has undergone four lumbar spine surgeries in the form of discectomies and fusions that were performed by Dr. ES. Claimant also underwent one lumbar hardware removal surgery that was performed by Dr. RF. Claimant has been under the care of orthopedic surgeon, Dr. KB, since October 10, 2011. Dr. B has diagnosed Claimant with lumbar disc displacement and sacroiliac sprain. Claimant is currently receiving anti-inflammatory medications and pain medications to help alleviate some of his symptoms. Dr. B has recommended a right sacroiliac joint injection to further reduce Claimant's pain. Three utilization reviews were conducted. The URAs denied the request because they did not feel that the medical records established that Claimant had the clinical signs and symptoms of SI joint dysfunction.

Dr. B appealed the Carrier's decision to an IRO. The IRO upheld the Carrier's denial. The IRO stated that "the diagnosis of sacroiliac dysfunction and the sacroiliac joint as a pain generator is somewhat difficult. The only tests of sacroiliac joint function documented at this time are FABER tests and distraction tests. It would appear that this is insufficient to justify intraarticular injections at this time." Dr. B appealed the IRO decision to a Medical Contested Case Hearing.

DISCUSSION

Texas Labor Code Section 408.021 provides that an employee who sustains a compensable injury is entitled to all health care reasonably required by the nature of the injury as and when needed. Health care reasonably required is further defined in Texas Labor Code Section 401.011 (22a) as health care that is clinically appropriate and considered effective for the injured employee's injury and provided in accordance with best practices consistent with evidence based medicine or, if evidence based medicine is not available, then generally accepted standards of medical practice recognized in the medical community. Health care under the Texas Workers' Compensation system must be consistent with evidence based medicine if that evidence is available. Evidence based medicine is further defined in Texas Labor Code Section 401.011 (18a) to be the use of the current best quality scientific and medical evidence formulated from credible scientific studies, including peer-reviewed medical literature and other current scientifically based texts and treatment and practice guidelines. The Commissioner of the Division of Workers' Compensation is required to adopt treatment guidelines that are evidence-based, scientifically valid, outcome-focused, and designed to reduce excessive or inappropriate medical care while safeguarding necessary medical care. Texas Labor Code Section 413.011(e). Medical services consistent with the medical policies and fee guidelines adopted by the commissioner are presumed reasonable in accordance with Texas Labor Code Section 413.017(1).

In accordance with the above statutory guidance, the Division of Workers' Compensation has adopted treatment guidelines by Division Rule 137.100. This rule directs health care providers to provide treatment in accordance with the current edition of the Official Disability Guidelines (ODG), and such treatment is presumed to be health care reasonably required as defined in the Texas Labor Code. Thus, the focus of any health care dispute starts with the health care set out in the ODG. Also, in accordance with Division Rule 133.308(s), "A decision issued by an IRO is not considered an agency decision and neither the Department nor the Division is considered a party to an appeal. In a Contested Case Hearing (CCH), the party appealing the IRO decision has the burden of overcoming the decision issued by an IRO by a preponderance of evidence-based medical evidence."

With regard to sacroiliac joint injections (blocks), the ODG provides as follows:

> Recommended as an option if failed at least 4-6 weeks of aggressive conservative therapy as indicated below. Sacroiliac dysfunction is poorly defined and the diagnosis is often difficult to make due to the presence of other low back pathology (including spinal stenosis and facet arthropathy). The diagnosis is also difficult to make as pain symptoms may depend on the region of the SI joint that is involved (anterior, posterior, and/or extra-articular ligaments). Pain may radiate

into the buttock, groin and entire ipsilateral lower limb, although if pain is present above L5, it is not thought to be from the SI joint.

Innervation: The anterior portion is thought to be innervated by the posterior rami of the L1-S2 roots and the posterior portion by the posterior rami of L4-S3, although the actual innervation remains unclear. Anterior innervation may also be supplied by the obturator nerve, superior gluteal nerve and/or lumbosacral trunk. (Vallejo, 2006) Other research supports innervation by the S1 and S2 sacral dorsal rami.

Etiology: includes degenerative joint disease, joint laxity, and trauma (such as a fall to the buttock). The main cause is SI joint disruption from significant pelvic trauma.

Diagnosis: Specific tests for motion palpation and pain provocation have been described for SI joint dysfunction: Cranial Shear Test; Extension Test; Flamingo Test; Fortin Finger Test; Gaenslen's Test; Gillet's Test (One Legged-Stork Test); Patrick's Test (FABER); Pelvic Compression Test; Pelvic Distraction Test; Pelvic Rock Test; Resisted Abduction Test (REAB); Sacroiliac Shear Test; Standing Flexion Test; Seated Flexion Test; Thigh Thrust Test (POSH). Imaging studies are not helpful. It has been questioned as to whether SI joint blocks are the "diagnostic gold standard." The block is felt to show low sensitivity, and discordance has been noted between two consecutive blocks (questioning validity). (Schwarzer, 1995) There is also concern that pain relief from diagnostic blocks may be confounded by infiltration of extra-articular ligaments, adjacent muscles, or sheaths of the nerve roots themselves. Sacral lateral branch injections have demonstrated a lack of diagnostic power and area not endorsed for this purpose. (Yin, 2003)

Treatment: There is limited research suggesting therapeutic blocks offer long-term effect. There should be evidence of a trial of aggressive conservative treatment (at least six weeks of a comprehensive exercise program, local icing, mobilization/manipulation and anti-inflammatories) as well as evidence of a clinical picture that is suggestive of sacroiliac injury and/or disease prior to a first SI joint block. If helpful, the blocks may be repeated; however, the frequency of these injections should be limited with attention placed on the comprehensive exercise program. (Forst, 2006) (Berthelot, 2006) (van der Wurff, 2006) (Laslett, 2005) (Zelle, 2005) (McKenzie-Brown 2005) (Pekkafahli, 2003) (Manchikanti, 2003) (Slipman, 2001) (Nelemans-Cochrane, 2000) See also Intra-articular steroid hip injection; & Sacroiliac joint radiofrequency neurotomy.

Recent research: A systematic review commissioned by the American Pain Society (APS) and conducted at the Oregon Evidence-Based Practice Center states that there is insufficient evidence to evaluate validity or utility of diagnostic sacroiliac joint block, and that there is insufficient evidence to adequately evaluate benefits of sacroiliac joint steroid injection. (Chou, 2009) The latest AHRQ Comparative Effectiveness Report, covering Pain Management Interventions for Hip Fracture, concluded that nerve blockade was effective for relief of acute pain; however, most studies were limited to either assessing acute pain or use of additional analgesia and did not report on how nerve blockades may affect rehabilitation such as ambulation or mobility if the blockade has both sensory and motor effects. (Abou-Setta, 2011)

Criteria for the use of sacroiliac blocks:

(1) The history and physical should suggest the diagnosis (with documentation of at least 3 positive exam findings as listed above).
(2) Diagnostic evaluation must first address any other possible pain generators.
(3) The patient has had and failed at least 4-6 weeks of aggressive conservative therapy including PT, home exercise and medication management.
(4) Blocks are performed under fluoroscopy. (Hansen, 2003)
(5) A positive diagnostic response is recorded as 80% for the duration of the local anesthetic. If the first block is not positive, a second diagnostic block is not performed.
(6) If steroids are injected during the initial injection, the duration of pain relief should be at least 6 weeks with at least > 70% pain relief recorded for this period.
(7) In the treatment or therapeutic phase (after the stabilization is completed), the suggested frequency for repeat blocks is 2 months or longer between each injection, provided that at least >70% pain relief is obtained for 6 weeks.
(8) The block is not to be performed on the same day as a lumbar epidural steroid injection (ESI), transforaminal ESI, facet joint injection or medial branch block.
(9) In the treatment or therapeutic phase, the interventional procedures should be repeated only as necessary judging by the medical necessity criteria, and these should be limited to a maximum of 4 times for local anesthetic and steroid blocks over a period of 1 year.

Dr. B testified that the Claimant meets the criteria outlined in the ODG regarding sacroiliac joint injections. Dr. B testified that he has performed specific tests for motion palpation and pain provocation to confirm the diagnosis of SI joint dysfunction. According to Dr. B's testimony,

and the medical records in evidence, Claimant's physical examination revealed positive FABER tests, distraction tests, and positive compression tests. Dr. B testified that he has ruled out other possible pain generators, such as radiculopathy and pain from the facet joints. Dr. B stated that facet injections are not indicated for Claimant's condition because he underwent a fusion surgery. Dr. B stated that after the fusion surgery there is no more motion in the facet joints. Therefore, it is unlikely that Claimant is experiencing pain in the facet region. Dr. B acknowledged that there is an EMG dated November 28, 2012 that indicates that Claimant has right SI radiculopathy. However, he stated that the Claimant's physical examination findings are not consistent with radiculopathy. Dr. B is providing medication management to Claimant. Dr. B testified that he has not requested physical therapy, because Claimant received all of the physical therapy that is recommended by the ODG. Dr. B stated that the block would be performed under fluoroscopy.

Dr. B persuasively established through his testimony the medical necessity of the requested procedure in this case. In particular, Dr. B's testimony demonstrated that the procedure is supported by the ODG. As a preponderance of the evidence-based medical evidence is found to outweigh the determination of the IRO on the medical necessity of the proposed procedure in this case, Claimant is held to be entitled to a sacroiliac joint injection with fluoroscopic control as health care reasonably required for the compensable injury of (Date of Injury).

The Hearing Officer considered all of the evidence admitted. The Findings of Fact and Conclusions of Law are based on an assessment of all of the evidence whether or not the evidence is specifically discussed in this Decision and Order.

FINDINGS OF FACT

1. The parties stipulated to the following facts:

    A. Venue is proper in the (City) Field Office of the Texas Department of Insurance, Division of Workers' Compensation.
    B. On (Date of Injury), Claimant was the employee of (Employer) Employer.
    C. Claimant sustained a compensable injury on (Date of Injury).

2. Carrier delivered to Claimant and Provider a single document stating the true corporate name of Carrier, and the name and street address of Carrier's registered agent, which document was admitted into evidence as Hearing Officer's Exhibit Number 2.

3. A sacroiliac joint injection is health care reasonably required for the compensable injury of (Date of Injury).

CONCLUSIONS OF LAW

1. The Texas Department of Insurance, Division of Workers' Compensation, has jurisdiction to hear this case.

2. Venue is proper in the (City) Field Office.

3. The preponderance of the medical evidence is contrary to the decision of the IRO that a sacroiliac joint injection is not health care reasonably required for the compensable injury of (Date of Injury).

DECISION

Claimant is entitled to a sacroiliac joint injection for the compensable injury of (Date of Injury).

ORDER

Carrier is liable for the benefits at issue in this hearing. Claimant also remains entitled to medical benefits for the compensable injury in accordance with §408.021.

The true corporate name of the insurance carrier is **FIRE AND CASUALTY INSURANCE COMPANY OF CONNECTICUT** and the name and address of its registered agent for service of process is:

CORPORATION SERVICE COMPANY
211 EAST 7TH STREET, SUITE 620
AUSTIN, TX 78701-3232

Signed this 30th day of April, 2014.

Jacquelyn Coleman
Hearing Officer